

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESFORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>Poc # 2</i>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445017		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/23/2012	
NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT MARYVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441 SS=D	<b>483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			F 441	• F 441 – Proper signage for isolation was placed by the ADON on 7/23/12 for Resident # 5, #7, and #8.  All rooms for residents requiring isolation were audited for proper isolation signage by the ADON on 7/24/12.  Under the Director of Nursing supervision, the Education Coordinator conducted an in- service for all staff, beginning 8/14/2012 and completed with all working staff 8/17/2012, on proper protocol for infection control and isolation precautions.		8-9-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Lisa L. Blevins**Administrator*

8/9/12

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 441	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, observation, and interview, the facility failed to implement isolation precautions to prevent the development and/or transmission of infection for three residents (#5, #7, #8) of nine sampled residents.</p> <p>The findings included:</p> <p>Review of facility policy titled "Initiating Isolation" dated May 20, 2003, revealed, "Isolation precautions will be initiated when there is reason to believe that a resident has an infectious or communicable disease...nurse shall notify the resident's attending physician for appropriate isolation instructions...enter the physician's order...shall remain in effect until discontinued by the attending physician or when criteria are met...When isolation precautions are implemented, the infection control coordinator or designee shall...Post the appropriate isolation notice on the room entrance door so that all personnel will be aware of isolation precautions..."</p> <p>Review of facility policy titled "Infection Control Policies/Practices" dated June 26, 2002, revealed, "...This facility's infection control policies and practices apply equally to all personnel, consultants...residents, visitors, volunteer workers, and the general public alike...The objectives of our infection control policies and practices are...Establish guidelines to follow in the implementation of isolation precautions..."</p>	F 441	<p>The Social worker re-educated the resident family members and visitors regarding compliance with the facilities Infection Control policies and procedures. Education with families of residents # 7 and #8 occurred on 7/13/12 and 8/7/12. Isolation precautions are discussed with families by the LPN and/or the MD when the orders are received.</p> <p>The Director of Nursing will conduct random audits on residents requiring isolation to assure proper placement of isolation signage and compliance with isolation and infection control procedures beginning the week of 8/13/2012. Audits will consist of 5 residents per week for 4 weeks, then 5 residents per month for 3 months.</p>		

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F 441	<p>Continued From page 2</p> <p>Medical record review revealed a hospital discharge summary, for resident #5, dated May 25, 2012 which revealed, "...pneumonia...has grown a multi-drug resistant acinetobacter from sputum culture..." Medical record review of a Nurse Practitioner (NP) note dated June 29, 2012, revealed, "history acinetobacter from bronchus...sputum pending...hold treatment for pneumonia unless symptoms worsen in light of acinetobacter..."</p> <p>Medical record review revealed Resident #5 was readmitted to the facility on June 27, 2012, with diagnoses including Acute Respiratory Failure and Pneumonia.</p> <p>Medical record review of a hospital discharge summary dated May 25, 2012, revealed, "...pneumonia...has grown a multi-drug resistant acinetobacter from sputum culture..." Medical record review of a Nurse Practitioner (NP) note dated June 29, 2012, revealed, "history acinetobacter from bronchus...sputum pending...hold treatment for pneumonia unless symptoms worsen in light of acinetobacter..."</p> <p>Medical record review of a physician's order dated June 29, 2012, revealed, "Isolate for Respiratory and Contact due to hx (history) + acinetobacter and diarrhea." Medical record review of a Result Form dated July 2, 2012, revealed, "Lower Respiratory Culture...Specimen Description Tracheal Aspirate...Culture Oropharyngeal Flora Present 3+ Acinetobacter... (Multiple Antibiotic Resistant Organism)...3+ Methicillin Resistant Staphylococcus Aureus..."</p> <p>Observation on July 12, 2012, at 3:45 p.m.,</p>	F 441	<p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months beginning in September 2012 and policies or procedures will be modified based on recommendations made as appropriate.</p>		

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F 441	<p>Continued From page 3</p> <p>revealed the resident in bed, a tracheotomy tube (to facilitate breathing) was used and a bio-hazard trash can and a regular trash can were in the resident's room. Continued observation revealed the door to the resident's room fully opened into the resident's room and a posted sign on the door (not visible from outside the resident's room) instructed visitors to see a nurse before entering the resident's room. Continued observation revealed an isolation cart across the hall from the resident's room.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on July 12, 2012, at 4:07 p.m., in the third floor day room, revealed isolation carts were placed on one side of the hall as a safety measure. Continued interview revealed staff had been inserviced regarding acinetobacter and instructed posting of isolation signs violated a resident's right to privacy.</p> <p>Interview with the Assistant Director of Nursing (ADON) on July 23, 2012, at 3:50 p.m., in the third floor family room, confirmed the facility failed to implement isolation precautions for Resident #5.</p> <p>Resident #7 was admitted to the facility on September 1, 2010, with diagnoses including Urinary Tract Infection, Pneumonia, and Acute and Chronic Respiratory Failure and readmitted on July 12, 2012.</p> <p>Medical record review of Admission Orders dated July 12, 2012, on July 20, 2012, revealed, "...Isolation Yes Type: Acinetobacter - contact precautions..."</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER

**ASBURY PLACE AT MARYVILLE**

STREET ADDRESS, CITY, STATE, ZIP CODE

**2648 SEVIERVILLE RD****MARYVILLE, TN 37804**

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F 441	<p>Continued From page 4</p> <p>Observation on July 20, 2012, at 3:15 p.m., revealed the resident in bed, a tracheotomy tube was used, and another resident was in the room. Continued observation revealed a visitor in the room (in the roommate's side of the room) without gloves or a gown and a sign posted outside the room instructed visitors to see a nurse before entering the room.</p> <p>Interview with LPN #3 on July 20, 2012, at 3:23 p.m., at the third floor nurse's station, revealed a gown, gloves, and a mask were to be donned before entering the room and the resident's mother was non-compliant with isolation precautions.</p> <p>Interview with the Assistant Director of Nursing (ADON) on July 23, 2012, at 3:50 p.m., in the third floor family room, revealed the Medical Director instructed staff isolation precautions continued until a resident had no symptoms of infection. Continued interview confirmed the facility failed to implement isolation precautions for Resident #7.</p> <p>Resident #8 was admitted to the facility on June 26, 2012, with diagnoses including Acute and Chronic Respiratory Failure, Quadriplegia, and Pseudomonas Pneumonia.</p> <p>Medical record review of a Result Form dated July 11, 2012, revealed, "...Wound Culture...Specimen Description...trach (tracheostomy) stoma...Organism 1 3+ Pseudomonas Aeruginosa...Organism 2 2+ Acinetobacter..." Medical record review of a</p>	F 441		

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F 441	<p>Continued From page 5</p> <p>Hepatitis Panel report dated July 5, 2012, revealed, "...Reactive Reference Range Non-reactive..." Continued review revealed the resident had Hepatitis C.</p> <p>Observation on July 20, 2012, at 3:17 p.m., revealed the resident in bed, a tracheotomy tube was used, and a female (visitor) held the siderail of the resident's bed. Continued observation revealed a sign posted on the door instructed visitors to check with a nurse before entering the room. Continued observation revealed the female did not wear gloves or a gown, removed a mask as she left the room, and did not wash her hands.</p> <p>Interview with LPN #3 on July 20, 2012, at 3:23 p.m., at the third floor nurse's station, revealed a gown, gloves, and a mask were to be donned before entering the room.</p> <p>Interview with the ADON on July 23, 2012, at 1:30 p.m., in the third floor family room, confirmed the facility failed to implement isolation precautions for Resident #8.</p>	F 441			